DENTAL HYGIENE LOCAL ANESTHESIA APPLICATION

NAME:_____
ADDRESS: _____
PHONE NUMBER:_____

Fee: Anesthesia credentialing application fee $30.00
WREB anesthesia application fee $10.00
Make check payable to the "Montana Board of Dentistry"

_____Permit requested by WREB examination within 5 years : If you are requesting a local anesthesia permit using the WREB anesthesia examination within the last 5 years, please send a copy of the examination certificate with this application, along with the check for the appropriate fee. DO NOT COMPLETE THE SECTION BELOW.

_____Permit requested by credentialing of WREB longer than 5 years:

Please answer the following questions for credentialing only:

1) Are you currently licensed in the State of Montana as a dental hygienist?_____
2) Are you in the process of applying for a Montana dental hygiene license?_____

YOU MUST SUBMIT VERIFICATION: of successful completion of a local anesthetic agent course given by a commission on dental accreditation (CODA) accredited dental or CODA accredited dental hygiene school.

YOU MUST SUBMIT ONE OF THE FOLLOWING:

1) A letter from the school with the school seal affixed (original, no photocopies).
2) A notarized copy of the certificate of local anesthetic agent course completion.
3) A notarized copy of the dental or dental hygiene transcript with the local anesthetic agent course recorded.

PROVIDE THE FOLLOWING:

1) Verification of successful completion of a WREB clinical local anesthetic agent examination.
2) Copy or copies of any local anesthetic agent license held in another state/s.
3) Written third party verification that the applicant has practiced administering local anesthetic agents within the last five years.

I certify that the information submitted and all questions are true and accurate to the best of my knowledge.

Signature of Applicant:_____Date:_____

(You may copy this portion of the application if you need more than one verification)

VERIFICATION FOR ADMINISTRATION OF LOCAL ANESTHESTIC AGENTS WITHIN THE LAST FIVE YEARS:

Name of Dentist/Entity:_____

Address:_____

City/State/Zip:_____

Phone/Fax:_____

Period of Time practicing local anesthetic agents:_____

SIGNATURE DATE

Office use only: Approved for local anesthetic by credentialing_____